DOCUMENTATION OF COMPETENCY

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES/HCBS
SFN 750 (10-2006)

Name:

INDIVIDUAL REQUEST FOR QUALIFIED SERVICE PROVIDER

The Documentation of Competency must be completed or updated a minimum of one time every two years. Failure to have the Documentation of Competency updated every two years results in automatic termination of Qualified Service Provider status.

(1)	(2) STANDARD	(3) COMPETENT		(4) How Determined Standard		
		Yes	No	Return	Verbal	Written
5.	Proper handwashing methods					
6.	Handling of body fluids					
7.	Bathing techniques					
8.	Hair care techniques					
9.	Oral hygiene techniques					
10.	Dress/undress client					
11.	Toileting					
12.	Caring for incontinence					
13.	Feed or assist with eating					
14.	Basic meal planning and preparation					
15.	Routine eye care (non-prescription eye drops/ointment)					
16.	Care of Fingernails					
17.	Self administration of medications					
18.	Skin care (non-prescription lotions, ointments, etc.)					
19.	Turning and positioning					
20.	Transferring					
21.	Ambulation					
22.	Routine housework					
23.	Wrinkle free bed					
24.	Laundry techniques					
25.	Managing a budget					

GLOBAL ENDORSEMENTS		COMPETENT		How Determined Standard		
		Yes	No	Return	Verbal	Written
A.	Maintenance Exercise					
B.	Catheter: routine care indwelling					
C.	Medical Gases: Established routine (oxygen only)					
D.	Suppository: Maintain bowel program (non-prescription suppository only)					
E.	Cognitive: Dementia impaired					
F.	Taking BP; TPR					
G.	Ted Socks (Surgical Stockings)					
H.	Prosthesis/Orthotics/Adaptive Devices					
I.	Hoyer lift/Mechanized bath chairs					

I certify that the above-named individual is competent in the identified standards, including those for endorsement(s), checked YES. The competency is based on the standards for direct care staff as outlined in the North Dakota Department of Human Services Qualified Service Provider Handbook.

Further, I certify that I have met the professional degree or have experience in the specialized area(s) required, explained on the back, to be qualified to sign this competency verification.

Signature:	Date:	Telephone Number:
Position/Title:	License Number:	Email Address:

FOR PERSON VERIFYING COMPETENCY: SEE INSTRUCTIONS ON BACK

INSTRUCTIONS

INSTRUCTIONS FOR PERSON CERTIFYING INDIVIDUAL REQUESTING QUALIFIED SERVICE PROVIDER STATUS:

The person signing the Documentation of Competency (SFN 750) must be one of the following health care professionals: physician, physician's assistant, nurse practitioner, registered nurse, licensed practical nurse, physical therapist, occupational therapist.

Column (1): The standards checked are those that the individual has identified requesting Qualified Service Provider status as needing to be verified for competency for the service(s) that the individual intends to deliver.

Column (2): **STANDARDS** - Listed is a brief explanation of each. The full explanation of the standards and documentation required is found in the Department of Human Services Qualified Service Provider Handbook, Standards for Service Delivery.

Column (3): **COMPETENT** - Place an X in the YES box if the individual is found competent in this standard or mark NO if the individual did not meet the requirement for competency.

Column (4): **HOW DETERMINED STANDARDS** - Place an X in the column that identifies the means by which the competency was verified:
RETURN - You actually observed the demonstration of the procedure being performed.
VERBAL - A **detailed** verbal explanation of the procedure was provided to you.
WRITTEN - A **detailed** written explanation of the procedure was read by you.

The following endorsements are **Global Endorsements.** The competency for each task will apply to all clients for whom the provider delivers care:

A. Maintenance Exercise
B. Catheter (can not be verified by an Occupational or Physical Therapist)
C. Medical Gases (can not be verified by an Occupational or Physical Therapist)
D. Suppository (can not be verified by an Occupational or Physcial Therapist)
E. Cognitive
F. Taking BP/TPR
G. Ted Socks (Surgical Stockings)
H. Prosthesis/Orthotics
I. Hoyer Lift/Mechanized bath chair

SIGN AND DATE THIS FORM. IDENTIFY YOUR CREDENTIAL(S) AND YOUR LICENSE NUMBER.